5 COORDINATION/INTEGRATION *Effective: 7/1/97*
5.4 Health Services *Revised: 3/1/98*

POLICY: Each applicant/participant shall be provided with appropriate health care referrals per agency/project protocol. WIC services should be coordinated with other health services provided by the local agency and within the community. Memoranda of understanding are encouraged in order to delineate responsibilities and to facilitate coordination of care. For policy and procedures pertaining to nutrition services, see Policy 5.5 Nutrition Services.

PROCEDURE:

A. ROUTINE PRIMARY HEALTH CARE SERVICES

1. At the initial certification, assess the WIC applicant's participation in routine primary pediatric or obstetric care and refer as needed.

    a) Review the WIC Questionnaire to determine if the applicant indicated their physician's name and clinic. If these are not filled in, it is recommended to ask the applicant and document the physician's name and clinic on the Questionnaire or Risk Factor Flow Sheet.

    b) If the applicant does not have a primary health care provider, refer the applicant to public health nursing or to a health care provider, as established by project/agency protocol. Document the referral. Note: Participants in the MA Program who are enrolled in managed care organizations (MCOs or HMOs) must receive MA-covered services from managed care providers (with the exception of Prenatal Care Coordination). Managed care providers, however, may contract with local health departments or other agencies for the provision of some services, e.g., HealthCheck.

    c) Provide the applicant with information (verbally or written) on the types of health services available, where they are located, how they may be obtained, and why they may be useful.

    d) Professional WIC staff are responsible for making referrals to health care providers outside the agency.

    e) See the Confidentiality Policy in the Administration Chapter for policies and procedures pertaining to disclosure of participant information.

f) Follow-up on the referral at the next visit, at the latest. If the participant did not follow-through on the referral, use professional judgment to determine whether or not to refer again or to refer to another health care provider.

2. At subsequent certifications, assess participation in and need for health services, and when appropriate, provide information or refer them to such services. Document accordingly.

B. OTHER HEALTH SERVICES

During certifications or individual secondary nutrition education contacts, the need for additional services may be identified (see the WIC Certification and Secondary Nutrition Education Guidelines in Policy 3.30). The following are examples of other programs/services which may be available locally. Current WIC requirements and recommendations are noted.

1. Pregnant Women:

a) Prenatal Care Coordination (PNCC). PNCC is a program for MA-eligible pregnant women who are at risk of having a low birth weight baby, a preterm birth, or other adverse birth outcome or who may have difficulty obtaining proper medical care. Services include outreach, risk assessments, care planning and coordination, prenatal health education, and nutrition counseling. Similar services may be available through Maternal and Child Health Block Grants for women who are not MA-eligible but who are still at risk for poor birth outcomes.

(1) Projects should know and contact the prenatal care coordination providers in the project area. Contact the local health department(s) if information is needed.

(2) A State MOU allows the disclosure of WIC participant information to PNCC (see BPH/BHCF MOU in Policy 5.9 State and Local WIC Memoranda of Understanding).

(3) Local MOUs, agreements, or policies, with formal referral procedures (including provision of additional nutrition services), are recommended. PNCC guidelines require coordination of services including risk assessment and basic nutrition education. WIC CPAs and RDs should know the eligibility criteria, refer, share risk information and care plan goals, and follow-up at the next WIC visit.

b) Childbirth/delivery classes/education: There is a question on the Prenatal Questionnaire that asks if the woman is interested in information on childbirth/delivery. If she is, the provision of information on prenatal

childbirth classes (e.g., La Maze) is recommended. Contact the local health department(s) if information on services/programs available in the project area is needed.

c) Breastfeeding promotion (see Policy 3.40 Breastfeeding Plan)

d) Other services for pregnant women, such as the School Age Mother Program (prenatal health education, parenting support, and possibly HealthCheck visits for infants), may also be available. Contact the local health department for information.

2. Infants and Children:

a) Immunizations. There is a statewide initiative to increase the immunization rates of children under two years of age. WIC is an excellent resource for education, screening, and referral to immunization providers.

(1) A State MOU allows the disclosure of participant information (e.g., name, address, immunization status) for the purpose of immunization follow-up (see WIC/Immunization MOU in Policy 5.9).

(2) Required Immunization Coordination Activities:

(a) Orient WIC clinic staff on the basic immunization schedule.

(b) Educate caregivers on the importance and availability of immunizations.

(c) Participate in the planning and implementation of effective collaboration with local health departments and other providers, e.g., managed care providers.

(d) Establish protocol for referral with immunization providers, considering the confidentiality policy.

(e) Request that participants bring a documented immunization record for their child to each certification appointment.

(f) At each certification until the primary series is completed, assess all infants' and children's immunization status and enter the appropriate status code in DAISy.

(g) Refer infants and children who are behind on immunizations or whose statuses are unknown per agency protocol. See the WIC/Immunization MOU in Policy 5.9.

(h) Track the referral at the next WIC certification appointment (at a minimum) or the next draft issuance (recommended).

(i) Review immunization activities for appropriate cost sharing.

(3) Optional Immunization Activities:

(a) Enter immunization dates into DAISy for an automated immunization record assessment.

(b) Meet with local health department staff to discuss specific barriers to immunizations for clients.

(c) Share the WIC Immunization report with appropriate providers to assist with immunization initiatives, considering the confidentiality policy.

(d) Assess feasibility of co-locating Immunization and WIC clinics.

(e) Develop strategies, as needed, to assure immunization records are available and accessible to the caregiver, and brought to the WIC clinic when requested.

(f) Review best practices for education, screening, referral, provision of immunization, and tracking to determine which strategies work best in the WIC clinic.

(g) Work with local health departments to assess accessibility and availability of immunization providers as needed.

(h) Escort client to immunization services within the building.

b) Lead Poisoning Prevention. Collaboration with lead poisoning prevention and follow-up activities in the local health department is recommended. See also Available resources and References at the end of this policy.

(1) Screening for sources of lead: The WIC Questionnaires contain a question pertaining to drinking water source and other questions pertaining to possible lead exposure. See Policy 5.5 for information on education and referrals regarding lead in water.

(2) Blood lead testing: When doing hemoglobin or hematocrit tests at certifications, WIC screeners may collect an extra sample of blood from the same finger stick, using proper blood lead sampling procedures, to send to the State Laboratory of Hygiene or other laboratory for lead testing. See Policy 11.1 regarding Unallowable Costs. The Centers for Disease Control and Prevention (CDC) and the Wisconsin Division of Health recommend blood lead testing for infants and children based on potential exposure to lead (starting at 6 months of age if at risk for lead exposure; at 12 months of age for others). HealthCheck requires tests at 12 month and 24 months, and will cover tests at 6 months and at other times as needed for follow-up on high levels.

(3) Counseling: HealthCheck may provide follow-up services, including nutrition counseling, for children with high blood lead levels.

c) Children with developmental disabilities/delays or chronic health conditions. Local projects should know the procedures for helping these children obtain the services they need, including nutrition services.

(1) Resources for these children are described below. See the Outreach Manual for more information.

(a) Birth to Three Program. The Birth to Three Program is a comprehensive statewide system of early intervention services for young children with developmental disabilities or developmental delays. Services are provided based on ability to pay. Each county has an established referral network which may include parents, child care providers, physicians, nurses, dietitians, public health staff, clinics, teachers, family resource centers, and other providers of services to families.

(b) Katie Beckett Program. This Medicaid program provides benefits to children with long-term disabilities or complex medical needs who live at home but whose family income and assets are too high to qualify for the Supplemental Security Income (SSI) program. There are ten Katie Beckett Consultants serving all 72 counties who handle applications. In general, the Birth to Three Program or health department nurse would refer the client, but WIC can also. Contact the local health department(s) or local Birth to Three program if information on contacting the Consultant is needed.

(c) Supplemental Security Income (SSI) is a state and federal cash assistance program for disabled or blind children and adults who have limited income and assets. SSI recipients are also eligible for out-of-

home care and rehabilitation services. For more information, contact a local Social Security Administration Office.

(d) Children with Special Health Care Needs (CSHCN) Program. This program, located in the Bureau of Public Health, Maternal and Child Health Section, provides consultation, advocacy and financial assistance to families with children who have chronic illnesses or disabling conditions. MCH providers and advocates may call the MCH Hotline (800/722-2295) for the telephone number of the nurse specialist serving each county.

(e) Congenital Disorders Program. This program, located in the Bureau of Public Health, provides special dietary treatments and medical nutrition therapy for PKU and other disorders identified as a result of newborn screening. For information on services, call 608/266-8904.

(2) Local MOUs, agreements, or policies, including formal referral procedures (including policies and procedures for additional nutrition services), with the Birth to Three Program are recommended.

3. Postpartum Breastfeeding and Nonbreastfeeding Women:

a) Family Planning. Family planning services are available through Title X (federal family planning funding) and through Title V (Maternal and Child Health Block Grants). Contact the local health department(s) for information on family planning services in the project area.

(1) There is a question on the Prenatal and Postpartum Questionnaires that asks if the woman is interested in information on birth control/family planning. If she is, the provision of information on available family planning services or a referral is recommended.

b) Breastfeeding Support (see Policy 3.40 Breastfeeding Plan)

4. All Participants:

a) Dental Care. The Child, Prenatal, and Breastfeeding/ Postpartum Questionnaires contain a question asking about the last dental visit. In addition, the Child form asks about dental problems. The following referrals are recommended:

(1) Refer women to a dentist if they have not had a dental visit within the last year (MA covers this).

(2) Refer children to a dentist, as needed. The recommendation is a first visit at 12 months of age, with the periodicity schedule thereafter established by the dentist. MA covers this; HealthCheck also covers sealants.

(3) If local dentists do not accept MA clients, provide information anyway (in the event the participant decides to pay for dental care) and stress the importance of dental care.

b) Substance Use and Abuse

(1) At certifications of all women, assess smoking and alcohol and drug use, using the questions on the Prenatal and Breastfeeding/Postpartum Questionnaires.

(a) Enter the appropriate Smoking and Alcohol use codes in DAISy.

(b) Per the WIC Risk Factor Criteria, identify risk factors.

(2) Maintain and make available for distribution to all pregnant, postpartum, and breastfeeding women and to parents or caregivers of infants and children applying for and participating in WIC a list of local resources for drug and other harmful substance abuse counseling and treatment.

(3) Refer pregnant, breastfeeding, and postpartum women for whom further assessment or treatment for substance abuse is needed, if indicated. It is recommended to refer pregnant women and postpartum breastfeeding and nonbreastfeeding women up to 60 days postpartum to a Prenatal Care Coordinator, rather than directly to a substance abuse program.

(4) Provide information on the dangers of smoking and alcohol and drug use to all women and caregivers of infants and children at least once. Information may be provided verbally, in writing, by an audiovisual, or other method.

C. COLLABORATION WITH LOCAL HEALTH DEPARTMENTS (LHDs)

Because public health nurses and educators know the full range of services available to the WIC population, WIC projects should collaborate with LHDs to learn about the services available to the WIC population, determine effective referral and follow-up procedures, methods to improve services, etc.

1. Examples of services to discuss with LHDs include:
   a) Prenatal care coordination and supportive services
   b) Substance use and abuse assessment, counseling, and treatment
   c) HealthCheck

d) Medicaid Targeted Case Management
e) Milwaukee Family Project
f) Immunizations/Milwaukee Immunization Project
g) Birth to Three and other resources for children with special health care needs (e.g., Katie Beckett Program, SSI)
h) Lead poisoning prevention
i) Women's and homeless shelters
j) Parenting and growth and development services
k) Home visiting services available to the WIC population

2. A Model Memorandum of Understanding (MOU) between local WIC projects and local health departments (see attachment in Policy 5.9) was developed by the Bureau of Public Health and sent to local Health Department Health Officers and WIC Project Directors in March, 1996. The intent of the Model MOU is to serve as the framework for the development of local MOUs. MOUs patterned after the Model will streamline communications and the sharing of information concerning the health of children and their families, while adhering to state and federal statutes and policies concerning confidentiality.

D. OTHER SERVICES/PROGRAMS

There may be other programs/services in the WIC service area that are of benefit to the health and well being of the WIC population, e.g., housing, day care, energy assistance, etc. It is a local decision to determine the extent of WIC involvement.

NOTES:

Available resources:

* USDA, FNS: Providing Drug Abuse Information and Referrals in the WIC Program: A Local Agency Resource Manual, 1991. (Sent to WIC projects from USDA in 1992)
* Green M (ed): Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents. Arlington, VA: National Center for Education in Maternal and Child Health, 1994. (Sent to WIC projects from the MCH Section in February, 1995)
* National Center for Education in Maternal and Child Health: "Nutrition and Childhood Lead Poisoning Prevention: A Quick Reference Guide for Health Providers" June, 1994. (Sent to WIC projects in the September, 1994 Nutrition Update.)

References:

* Centers for Disease Control and Prevention: Preventing Lead Poisoning in Young Children. US DHHS/PHS/CDC, October, 1991.
* Medical College of Wisconsin, Northern Wisconsin Area Health Education Center, University of Wisconsin School of Nursing, Division of Health Childhood Lead Poisoning Prevention Program: Preventing Childhood Lead Poisoning in Wisconsin: Information for Healthcare Providers of Children, 1995. (POH 9286)